MEDICAL EXPENSES CLAIM FORM EMD-084

Washington Military Department
Emergency Management Division

INSTRUCTIONS:

1. This form is in three parts: Part One must be completed by the emergency worker (or as described in #6, below); Part Two must be completed by the local emergency management director; and, Part Three must be completed by the attending physician.
2. All responses must be in ink and all requested items must be completed.
3. Claimant must be a registered Emergency Worker in accordance with Revised Code of Washington (RCW) 38.52, and Washington Administrative Code (WAC) 118-04, and must have been working under Emergency Management authority at the time of the accident.
4. A state Mission/Incident number, Training Mission number, or Evidence Search Training Mission number must have been assigned.
5. When completed, this form must be signed by claimant or claimant's representative.
6. Claimant's social security and health care provider's tax ID number must be included with claim.
7. If claimant is unable to present and file the claim (due to incapacitation, etc.) or if claimant is a minor, or a nonresident of the state, the claim may be presented and filed on behalf of the claimant by any relative, attorney, or agency representing the claimant.
8. If total claim for mission/incident number exceeds $2,000.00, before sending in the claim, a compensation board must be established in accordance with RCW 38.52.210. Contact Washington Emergency Management Division for further information.
9. If medical treatment or care will continue for an extended period, call the Emergency Management SAR coordinator for instructions on dealing with the claim.

Submit original claim and all supporting documentation to your local Director of Emergency Management or Search and Rescue Coordinator (WAC 118-04-360).

PART ONE:
TO BE COMPLETED BY EMERGENCY WORKER (CLAIMANT) OR REPRESENTATIVE

NAME OF CLAIMANT: _____
Last First M.I.

CLAIMANT'S ADDRESS: _____

_____
City State Zip

SOCIAL SECURITY NO. _____

EMERGENCY WORKER CARD NUMBER: _____

COUNTY WHERE REGISTERED: _____

HOME PHONE: (___)_____

WORK PHONE: (___)_____

COUNTY MISSION/INCIDENT TOOK PLACE: _____

MISSION OR INCIDENT # _____

DATE OF INCIDENT: _____

TOTAL AMOUNT OF CLAIM: $_____

FULL DESCRIPTION OF CIRCUMSTANCES SURROUNDING THE INCIDENT AND A DESCRIPTION OF THE INJURY(S) RECEIVED AS A RESULT: _____

_____

_____

_____

(If more space is needed, please attach additional sheets)

IF TIME WAS LOST FROM WORK:

Actual or Estimated Time Lost (dates): _____ Salary Per Week: $_____

Full Name of Husband or Wife at the Time of Incident: _____

If Divorced, Final Decree Date: _____

NOTE: If divorced and you have minor children, submit a copy of the court order showing legal custodian of such children. Also, give present address of such custodian. **Give name and birth date of your children under 18 supported by you.**

FULL NAME	RELATIONSHIP	DATE OF BIRTH MO. | DAY | YEAR

(If more space is needed, please attach additional sheets)

WAS THE INCIDENT COVERED BY PRIVATE INSURANCE? [YES] [NO]

IF YES, NAME, ADDRESS AND POLICY NUMBER OF INSURANCE COMPANY: _____

_____

_____

WAS A PORTION OF THE INCIDENT DEDUCTIBLE FROM THE POLICY BENEFIT? [YES] [NO]
HAVE YOU MADE A CLAIM AGAINST THE INSURER? [YES] [NO]
HAVE YOU MADE A SETTLEMENT WITH THE INSURER? [YES] [NO]
IF SO, WHAT AMOUNT? $ _____

EMERGENCY WORKER (CLAIMANT) OR LEGAL REPRESENTATIVE MUST SIGN THIS FORM

I hereby certify or "declare" under penalty of perjury under the laws of the State of Washington that the foregoing is a true and correct claim for necessary expenses incurred by me or claimant and that no payment has been received by me or claimant on account thereof.

_____ _____ _____
Signature of Emergency Worker (Claimant) Date Address

_____
City County

If the Claimant is incapacitated from verifying, presenting, and filing the claim or if the claimant is a minor, or is a nonresident of the state, the claim may be verified, presented, and filed on behalf of the claimant by any relative, attorney, or agent representing the claimant. All claims for damages against the state arising out of tortuous conduct shall be presented to and filed with the Risk Management Office.

(NOTE: For general statutory provisions governing claims against the State of Washington, see chapter 4.92.100 RCW. For specific information regarding Emergency Management Worker Claims, see RCW 38.52 and chapter 8, Laws of 1971, 1st Extraordinary Session, Section 4)

PART 2
TO BE COMPLETED BY THE EMERGENCY MANAGEMENT/SERVICES DIRECTOR FOR THE JURISDICTION WHERE INCIDENT OCCURRED OR FOR THE JURISDICTION WHERE CLAIMANT IS REGISTERED.

I have reviewed the information in part one (1) and it is true to my best knowledge and belief.

_____ _____
Director's Signature Date

Don't forget to check:

[ ] Copy of DEM-075 with Emergency Worker name showing? [ ] Receipts as specified included? [ ] Form(s) properly filled out and signed?

Form EMD-084 (Rev. 10/99) All other versions are obsolete and should not be used.

PART THREE: TO BE COMPLETED BY ATTENDING PHYSICIAN

NAME OF INJURED EMERGENCY WORKER: _____

DATE OF FIRST TREATMENT: _____

WAS HOSPITALIZATION REQUIRED? [YES] [NO]

IF YES, NAME AND ADDRESS OF HOSPITAL: _____

_____

_____

HISTORY OF INJURY (if extremities involved, give right or left): _____

_____

_____

(If more space is needed, please attach additional sheets)

PHYSICAL FINDINGS IN DETAIL (if extremities involved, give right or left): _____

_____

_____

(If more space is needed, please attach additional sheets)

X-RAY FINDINGS: _____
DIAGNOSIS: _____

IF THE ILLNESS, INJURY, OR TREATMENT, AS DESCRIBED, IS RELATED TO ANY PREVIOUS ILLNESS, INJURY, OR TREATMENT; OR THAT THERE IS EVIDENCE OF PREEXISTING INJURY OR DISEASE OF THE AREA; OR THAT A PREEXISTING CONDITION WILL COMPLICATE TREATMENT, PLEASE EXPLAIN IN DETAIL: _____

_____

_____

_____

WILL THIS WORKER BE OFF OF WORK DUE TO INJURY? [YES] [NO]
IF YES, ESTIMATE TIME LOSS FROM REGULAR JOB DUE TO INJURY: _____ DAYS

WILL THERE BE ANY PERMANENT DISABILITY? [YES] [NO]
IF YES, EXPLAIN: _____

ATTENDING PHYSICIAN: PLEASE PRINT OR TYPE YOUR NAME AND ADDRESS:

NAME: _____

ADDRESS: _____

_____

TELEPHONE NUMBER: ( ) _____ PATIENT ACCOUNT#: _____

_____ _____

PHYSICIAN'S SIGNATURE DATE

(THIS REPORT CAN BE ACCEPTED <u>ONLY</u> WHEN COMPLETED AND SIGNED BY A LICENSED PHYSICIAN)